APPLICATION FOR ATHLETIC TRAINERS LICENSE

State Form 46715 (R5 / 7-02)
Approved by State Board of Accounts, 2002

INDIANA ATHLETIC TRAINERS BOARD
Health Professions Bureau
402 West Washington Street, Room 041
Indianapolis, Indiana 46204
Telephone (317) 232-2960

* Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without

Application fee
Date fee paid (*month, day, year*)
Receipt number
License number
License issuance date (*month, day, year*)

DO NOT WRITE ABOVE THIS LINE

APPLICANT
Attach two (2) passport type quality photographs of yourself taken within the last eight weeks.

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)		Social Security number *
Address (*number and street or Rural Route number*)		
City, state, ZIP code		E-mail address
Telephone number (*daytime*)	Birthdate (*month, day, year*)	Birthplace

Applying for licensure by:
☐ Endorsement from another state ☐ Examination

Are you an Indiana resident? ☐ Yes ☐ No	Are you performing athletic training in Indiana more than 180 days per year? ☐ Yes ☐ No

Do you desire a temporary permit?
☐ Yes ☐ No

ATHLETIC TRAINER EDUCATION

Pursuant to Indiana Code 25-5.1-3-1, applicants for licensure as an athletic trainer in the State of Indiana must show completion of the following accredited courses. Please indicate the institution at which you have completed the required courses. **Applicants using NATA approved or CAAHEP accredited curriculums and applicants using a NATA internship must complete the course information on this form.** Applicants must also provide an official transcript from each institution at which courses were completed or clinical experience was acquired.

Did you complete a NATA approved curriculum? ☐ Yes ☐ No	Name of institution
Type of degree received	
Located at (*city, state*)	Dates attended: (*month, year*) From To
Provide the total number of hours of athletic training experience you have completed under the supervision of a NATABOC certified athletic trainer while completing the requirements for this degree:	
Did you complete a NATA internship? ☐ Yes ☐ No	Name of institution
Type of degree received	
Located at (*city, state*)	Dates attended: (*month, year*) From To
Provide the total number of hours of athletic training experience you have completed under the supervision of a NATABOC certified athletic trainer while completing this internship:	These hours were completed: (*month, year*) From To
Human anatomy was completed at:	
Course title	Course number

ATHLETIC TRAINER EDUCATION (*continued*)	
Human physiology was completed at	
Course title	Course number
Physiology of exercise was completed at	
Course title	Course number
Kinesiology was completed at	
Course title	Course number
Personal health was completed at	
Course title	Course number
Basic athletic training was completed at	
Course title	Course number
Advanced athletic training was completed at	
Course title	Course number
Therapeutic modalities was completed at	
Course title	Course number
Rehabilitation was completed at	
Course title	Course number

OTHER EDUCATION AND TRAINING

INSTITUTION	CITY	STATE	ZIP CODE	FROM DATE	TO DATE	TYPE OF DEGREE RECEIVED

NATABOC CERTIFICATION

Date of certification	Certification number	Expiration date	Is your certification current? ☐ Yes ☐ No

List all places of athletic training related employment since graduation, including self-employment.

NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	HRS / WK	DATES

Do you hold, or have you ever held, a license, certificate, registration or permit to practice any regulated health occupation? ☐ Yes ☐ No

List all states, including Indiana, in which you have been licensed to practice any regulated health occupation.

TYPE OF LICENSE	STATE	NUMBER	DATE ISSUED	CURRENT STATUS

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details. Describe the event including location, date and disposition. If malpractice, provide name of plaintiff. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice athletic training or any regulated health occupation in any state (*including Indiana*) or country? ☐ Yes ☐ No
3. Are you now, or have you ever been treated for a drug abuse or alcohol problem? ☐ Yes ☐ No
4. Have you ever been charged with drug addiction? ☐ Yes ☐ No
5. Have you ever been convicted of, pled guilty or *nolo contendre* to:
   A. A violation of any Federal, State or local law relating to the use, manufacturing , distribution or dispensing of controlled substances or drug addiction? ☐ Yes ☐ No
   B. Any offense, misdemeanor or felony in any state? (*Except for minor violations of traffic laws resulting in fines*) ☐ Yes ☐ No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or ☐ Yes ☐ No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No
8. Have you ever had a malpractice judgement against you or settled any malpractice action? ☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date (*month, day, year*)

AUTHORIZATION FOR RELEASE INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any or its authorized representatives in connection with processing my application for athletic trainer certificating.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau and the Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Signature of applicant	Date (*month, day, year*)

VERIFICATION OF EDUCATION

TOP PORTION COMPLETED BY APPLICANT

Name of applicant (*last, first, middle, maiden*)	
Address (*number and street, city, state, ZIP code*)	
Date last attended (*month, year*)	Social Security number or ID number
Signature of applicant	Date of birth (*month, day, year*)

An appropriate official of the educational institution from which the applicant obtained the required degree must complete the remainder of this form. The school seal must be imprinted on this form. If there is no school seal, attach letter of explanation on letterhead. The President, Secretary, Dean, or Registrar of the named institution must sign this form. Return completed from to:

INDIANA ATHLETIC TRAINERS BOARD
402 WEST WASHINGTON STREET, ROOM 041
INDIANAPOLIS, IN 46204

As an official of the school named, I certify that the person named above received a degree as noted after fulfilling all requirements.

Degree received	Date of degree

SEAL	Signature
	Printed name
	Title
	Name of school
	If changed, present name
	City, state, ZIP code
	Date (*month, day, year*)

APPLICANT: The VERIFICATION OF EDUCATION form must be received before the Indiana Athletic Trainers Board will review your application. Any processing fees are the applicant's responsibility. The degree granting institution must send this form directly to the board at the address listed above.

** PLEASE REQUEST THAT THE SCHOOL ALSO SEND TO THE BOARD AN OFFICIAL COPY OF YOUR TRANSCRIPT.

VERIFICATION OF NATABOC EXAMINATION / CERTIFICATION STATUS

TOP PORTION COMPLETED BY APPLICANT

Name of applicant (*last, first, middle, maiden or previous*)

Address (*number and street or Rural Route, city, state, ZIP code*)

Social Security number or ID number	Email address

NATABOC certification number

I hereby give my permission to the NATABOC to release my examination results and certification status to the Indiana Athletic Trainers Board for the purpose of documenting my qualification for licensure as an athletic trainer in Indiana.

Signature of applicant	Date (*month, day, year*)

An appropriate official of the National Athletic Trainers Association Board of certification must complete the remainder of this verification form. Please ask the NATABOC to return this form directly to the Indiana Athletic Trainers Board. Mail this form along with a check or money order in the amount of fifteen dollars ($15.00), made payable to NATABOC, to the following address:

NATA Board Of Certification, Inc.
4223 S. 143rd Circle
Omaha, NE 68137

I hereby certify that the following person took and achieved the minimum passing score on the NATA Board of Certification Examination. (*If applicant has not been certified, please note same.*)

Name of applicant

Date of certification	Certification number	Applicant is in good standing?
		☐ Yes ☐ No

SEAL

Signature of NATABOC official

Printed name

Title

Date (*month, day, year*)

RETURN COMPLETED FORM TO:
INDIANA ATHLETIC TRAINERS BOARD
402 WEST WASHINGTON STREET, ROOM 041
INDIANAPOLIS, IN 46204

VERIFICATION OF SUPERVISION

Applicants applying for a temporary permit, who have not taken the NATABOC examination, must practice under the supervision of an athletic trainer who is licensed by the State of Indiana during the ninety (90) days in which the temporary permit is valid.

Applicants must forward this form to the licensed athletic trainer who will be supervising the applicant. The form must be completed, notarized and submitted to the Health Professions Bureau by the qualified supervisor.

This is to verify that _____ will be under my supervision while practicing athletic training. According to Indiana Code 25-5.1-3-8 (b), 898 IAC 1-1-9 and 898 IAC 1-4-1, I understand that I shall be available and under all circumstances shall be absolutely responsible for the direction and the actions of the person supervised when services are performed. I understand that the patients care shall always be my responsibility. I also understand that it is my responsibility to maintain records of experiential hours for the person being supervised.

Beginning date (*month, day, year*)	Signature of supervisor
Name of setting where supervision will occur	Printed name of supervisor
Address of setting where supervision will occur	Indiana license number of the supervisor
SEAL OF NOTARY PUBLIC	Date (*month, day, year*)
	Telephone number
	MAIL COMPLETED FORM TO: HEALTH PROFESSIONS BUREAU 402 WEST WASHINGTON STREET, ROOM 041 INDIANAPOLIS, IN 46204

TEMPORARY PERMITS ARE NOT AVAILABLE ON A WALK-IN PASIS.

NOTE: According to IC 25-5.1-3-8, a temporary permit expires the earlier of: (1) the date the person holding the permit is issued a license; (2) the date the Board disapproves the person's application of licensure; or (3) ninety (90) days after the date of issuance of the temporary permit.

VERIFICATION OF EMPLOYMENT / EXPERIENCE FOR ATHLETIC TRAINING LICENSURE APPLICANTS

APPLICANT: Complete the top section of this form, then forward it to your employer. You are authorized to photocopy this form as necessary.

Name of applicant (*last, first, middle, maiden or given surname*)		
Address (*number and street or Rural Route, city, state, ZIP code*)		
Social Security number *	Date of birth (*month, day, year*)	Telephone number (*daytime*)

I hereby authorize, _____ , to furnish the Health Professions Bureau of Indiana with the information below.

Signature of applicant	Date (*month, day, year*)

The remainder of this form must be completed, notarized and submitted by the employer. Please mail completed form to: Health Professions Bureau, 402 West Washington Street, Room 041, Indianapolis, IN 46204.

Name of employer		
Name of business / institution where employed		
Address of business / institution (*number and street, city, state, ZIP code*)		
Telephone number of business / institution ( )	Date employment began (*month, day, year*)	Date employment ended (*month, day, year*) (*If currently employed, please indicate*)
Number of hours applicant worked per week	Position held	

The applicant pursuant to my order, control, and full professional and legal responsibility as an employer has performed the above-indicated experience. I do hereby declare that the information contained herein is true and correct.

SEAL OF NOTARY PUBLIC	Signature
	Printed name
	Title
	Date (*month, day, year*)

ALL INFORMATION ON THIS FORM MUST BE TYPED OR CLEARLY PRINTED.